

Unearthing the Buried City

The Janet Translation Project

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This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life (p. 409).

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

Hysterical Anesthesia¹

Lecture given at the Salpêtrière on Friday, March 11th, 1892

By Mr. Pierre Janet

Agrégé Professor of Philosophy, Doctor of Letters, Student of the Department.

Gentlemen,

You are no doubt quite surprised to see a mere philosopher take the floor in these Friday lectures, which have already been graced by eminent clinicians. Do not hold it too much against me; it is my revered master—or rather, our master to all of us—Mr. Charcot, who thought that a lesson in pathological psychology would not be entirely out of place here. This opinion of Mr. Charcot will not surprise you: you know that he has never wanted to separate the study of the human mind from the study of the nervous system, and that through his influence and his own research, he has advanced psychology just as much as pathology. There are properly psychological doctrines that have entered even the official curriculum of the high schools and that belong to him: for many years now, all philosophy teachers speak annually to their students about the different types of memory—visual, auditory, motor—about speech disorders, and draw on the blackboard a famous diagram that you all know well. To speak only of the topic that must especially occupy us, you know that Mr. Charcot demonstrated the moral, psychological nature of hysterical paralyses—that he had the audacity to present certain flaccid paralyses, with an entirely physical appearance, as mere phenomena of thought. In doing so, he pointed out the path one must follow in order to study other symptoms of hysteria in the same way. So it is entirely natural that Mr. Charcot wished to hear, in the amphitheater of the clinic, the presentation of new studies on the mental state of hysterics that simply continue his own. As for me, I am very proud that Mr. Charcot chose me to present to you questions that interest him so deeply—I am proud above all that he has enough confidence in me to believe that my psychological analyses will not depart from medical truth, from clinical truth, to which everything here must be subordinated. I am also happy for this opportunity to express my gratitude to him. Ten or twelve years ago, when I was a philosophy teacher in the provinces, I came—without title or justification—to ask Mr. Charcot for some advice regarding the experimental psychology studies I wished to undertake. Mr. Charcot has no doubt forgotten this, but I still remember the kindness with which he received me, and the precious advice he gave me: I am one of his students more than he himself realizes. When later I came to work in his department, the sympathy and friendship I encountered here from everyone made the clinic's service dear to me.

¹ Janet, Pierre. “L'anesthésie hystérique,” Conférence fait à la Salpêtrière le 11 mars 1892, *Archives de Neurologie*, xxiii (1892), pp. 323-352.

And if my humble works can add even the smallest detail to the fine research that has been done in this department, I am happy to offer it to him.

Gentlemen, I intend to speak to you about the mental state of certain patients, but we must first agree on the meaning of that term. Formerly, in medical works, the title “mental state of the patient” brought together a few more or less general and more or less banal remarks about the patient’s character and behavior. One said, for example—speaking of hysterical women—that they laugh and cry without sufficient reason, that they get angry at every opportunity and without cause, that they have an unbearable character (which is fairly true), or that they are always liars (which is absurd). This is a description that is too superficial; it is what one might call drawing-room psychology—or, to use the expression of my excellent teacher Mr. J. Falret, it is nursemaid psychology. The ward servant knows better than you how unbearable the hysterical patient’s character can be; doctors must study something else. The term “mental state of a patient” must now designate, for the scholar, all the modifications that can occur in all psychological phenomena—in sensations, memories, perceptions, associations of ideas, etc. Later, perhaps in the twentieth century, all patients—from the simple rheumatic to the general paralytic—will have their psychology studied in meticulous detail. We shall see, unfortunately, from the difficulties presented by the psychological study of hysterical patients, that such an ideal is still far from being achieved.

I

I propose that we take as our starting point for the study of hystericals the analysis of *anesthesia*: this study is justified both by practical motives and by theoretical reasons. What often makes the examination of intellectual functions difficult is that, by their very nature, they are enclosed within the subject’s mind and only manifest externally through more or less observable symptoms. On the contrary, sensitivity and insensitivity are psychological phenomena whose effects are more easily accessible through external manifestations. One can easily verify whether certain sensory operations are carried out or not—this is not the case with memory, for instance—and anesthesia is the most convenient psychological fact to study experimentally. From the theoretical point of view, moreover, it is enough to remind you of the immense role that all psychologists have assigned to sensations in the formation of intelligence, and you will understand the importance of anesthesia in pathological psychology. This is why hysterical anesthesia must be the subject of our first psychological study. I am engaged in a psychological study, but rest assured: I intend to follow the example of those who have never been content to remain solely in abstract speculation. I will describe the facts to you and show them to you; it is only to explain these facts that we will allow ourselves a few hypotheses—and moreover, we will return to experimentation to verify our suppositions. To begin with clinical material and then return to the clinic, passing for a moment through the path of psychological hypotheses—this is the plan we will follow together in the study of hysterical anesthesia.

Rest assured, gentlemen, that I do not presume to describe for you all the clinical features of this anesthesia, which you know perfectly well; I will simply remind you of certain facts which we may perhaps have occasion to use. Thus, you know that anesthesia is very frequent in hystericals, and that it is rare to encounter the other symptoms of this illness without it being a case of anesthesia. M. Pitres, in his precise and careful work, states that “only 5% of patients are without anesthesia”²; in the service of M. Charcot, I do not know of a single one at the moment who is without it. Perhaps we shall have occasion to refer to those hystericals without anesthesia and to show that they nevertheless have a moral symptom not very different from it. You also know that this insensibility can be more or less complete, and that it can extend to all parts of the skin, all the mucous membranes, and all the sensory organs. One might say without exaggeration that if psychologists discover in a new sense something that had not yet been noticed, physicians will then find the next day that there exists a form of previously unsuspected hysterical anesthesia. The sense of touch in all its varieties—pain, temperature, contact, muscular sense—the sense of taste, of smell, of hearing, even sight: all can be affected separately or simultaneously. I do not need to remind you that certain anesthetics, such as that of sight, for example, can produce complex phenomena—diminished visual acuity, dyschromatopsia, and narrowing of the visual field. This last phenomenon—pardon the expression of this naïve feeling—causes me a certain admiration: I find that it is a beautiful psychological phenomenon. The extent of space perceived by a single glance, while the eye remains motionless, is reduced—that is, the number of objects visually perceived, which can, in an instant, penetrate into consciousness, is considerably diminished.

These anesthetics, whatever they may be, can appear in innumerable forms that we will group into certain classes; the division is no doubt not very precise, but it will allow us to make some psychological remarks about each category. Anesthetics can be *systematized*, *localized*, or *generalized*.

Systematized anesthetics are, in my opinion, more frequent than is generally believed, because they are not always noticed. They do not affect all the sensations coming from a given sense, but rather a group of sensations forming a system, while still allowing into consciousness the awareness of all the other phenomena supplied by that same sense.³ This type of insensibility, which is very interesting, is easy to observe during hypnotic sleep and to induce through appropriate suggestions. The subject, for example, will no longer see the people in the room unless a certain person is designated to them; they will be able to see objects, or papers handed to them, but will no longer be able to see a certain paper marked with a cross. The analysis of this phenomenon was, for me, the starting point in the study of hysterical anesthetics, but there is no need to insist on it here, as I will mainly focus on facts naturally produced by the illness. This

² A. Pitres, *Leçons cliniques sur l'hystérie*, 1891, I, p. 125.

³ On systematized anesthetics, consult two earlier studies: Pierre Janet, *L'Anesthésie systématisée et la dissociation des phénomènes psychologiques*, in *Revue philosophique*, 1887, I, p. 449, and *L'Automatisme psychologique*, 1889, p. 271. We ask permission to occasionally refer the reader to this latter work, in which certain psychological questions are treated with more development than it is possible to give in a single lecture.

systematized anesthesia is also and quite naturally found during somnambulism, whatever its origin. The somnambulist can see only a particular category, a particular system of objects related to their dream, and all others seem anesthetic to them. Automaton-like behavior was well described by Mr. Mesnet, who noted that his subject did not see her match but did see those presented by other people.⁴ A somnambulist I described could see very clearly that the lamp she had brought with her needed to be refilled, but did not see the people present trying to attract her attention.⁵ The same phenomenon even occurred the day before hysterical episodes. I have just read in the work of M. Gilles de la Tourette a precise observation of this kind: some hysterical women, he says, continue to sense certain tastes when presented by others but not when presented by themselves; a patient of his could no longer recognize the taste of onions.⁶ I myself once saw a patient whose case struck me as unusual: both of her hands were absolutely anesthetic, but she could still always recognize one of her two usual personal objects, belonging to her dressing set, such as a pair of earrings or a hair comb. Yet with the same hands, she could no longer feel a coin or a pencil, or, without a mirror, tell whether her hair was arranged to her liking. It seems here that sensitivity and insensitivity are distributed not according to physical causes, but according to certain ideas that determine the selection of impressions felt or not felt.

Among the *localized anesthetics*, we will focus especially on those that have been most effectively described by M. Charcot, under the name of “anesthetics in geometric segments.”⁷ In certain organs, or in parts of organs—a finger, a hand, or a thigh—one finds anesthetics throughout the surface, where the insensibility is limited by fairly regular lines, most often perpendicular to the axis of the limb. These distributions of anesthesia clearly do not correspond to anatomical regions—it is not the territory innervated by the ulnar or the median nerve that is anesthetic; it is the hand or the wrist. A patient currently being observed in the ward retained, as a result of a hysterical monoplegia in the process of recovery, a bracelet of anesthesia occupying exactly the wrist region, while sensitivity was intact in the hand and forearm. This is clearly not the territory of any specific nerve. Nor is it the vascular area irrigated by a single artery, as Briquet once supposed, in order to explain these distributions of anesthesia. No, the localization is not anatomical—it is physiological, as M. Charcot rightly said. But let me add a word: this distribution corresponds to a gross but real physiology. When a hysterical patient does not move a paralyzed hand, should the anesthesia be in the muscles that no longer function—that is, in the forearm? Yet, anesthesia is almost always limited to the hand itself and the wrist. In hysterical blindness, the anesthesia is not only on the retina, but also on the conjunctiva and even on the eyelids. The anarthric hysterical patient wears a monocle of anesthesia on her face. She no longer sees, not only physiologically, but in popular terms, that is, no longer sees “what the eye touches.” It seems that even in these localized

⁴ Mesnet, *Automatisme*, 1874, p. 19.

⁵ Selectivity or systematized esthesia, in *Automatisme psychologique*, p. 287.

⁶ Gilles de la Tourette, *Traité clinique et thérapeutique de l'hystérie*, 1891, p. 183.

⁷ *Leçons sur les maladies du système nerveux*, 1887, III, p. 345.

anesthesias, in the habitual associations of our sensations, ideas take over from nerves and muscles to determine the anesthesia.

Thirdly, anesthesias can be generalized, invading the entire surface of the body and more or less completely suppressing a given sensation or category of sensations. We have here another important observation to make, which already applied to the previous facts but which now becomes even more striking. Hysterical anesthesias are neither dangerous nor bothersome. They are not accompanied—at least ordinarily—by circulatory troubles, nutritional disorders of the affected parts, nor do they seem to disturb the normal functions of the organs. This is what is most often observed, and what is most important: the subject is unaware of their own anesthesias.⁸ Perhaps you do not realize how significant this trait is until you examine patients in the ward. Most of the patients who come here have already been examined by physicians sufficiently trained to identify hysterical stigmata, and they themselves alert us that they do not feel anything on the left side. This is something they have “learned”; when one observes a hysterical patient for the first time—or when one studies patients arriving from the countryside—one finds, as I have often noted before, that they show the deepest and most extensive anesthesias without knowing or suspecting it. Such is not the case for anesthesias of organic origin, and it suffices to recall a few well-known examples. You know how patients with that interesting and newly studied condition, syringomyelia, present themselves in the ward. They have burn marks on their fingers and complain of burning themselves each week without realizing it. Is it not the case that hysterical patients also often present with burn marks on their hands? Evidently not, and yet thermo-anesthesia is no less common in hysteria. You are also familiar with that particular symptom of tabes which M. Charcot was among the first to describe and which he called tabetic masking. Patients lose sensation in a more or less extended part of the face, but without being subjectively aware of it; they complain instead that part of their face has disappeared or has been torn off—a vague and monstrous impression. We often hear hysterical patients say that the anesthesia of one limb gives them the impression that it no longer exists.

Regarding this difference between the subjective sensations produced by hysterical anesthesia and those that accompany anesthesia of organic origin, allow me to recount a little anecdote. I did not collect it myself, but it was reported to me by my brother, Dr. Jules Janet. When he was an intern at La Pitié, under M. le Dr. Poalillon, he had the opportunity to observe the following case: A young girl in her twenties had been the victim of a fairly serious accident; she had fallen through a glass door and, unfortunately, a piece of glass had cut the lower part of her right hand, just below the thenar eminence. The bleeding was stopped and the wound healed quite well, but when the young woman came for consultation several days after the accident, she reported a certain numbness in the right hand, although paralysis was not evident. She complained above all of a persistent and rather troublesome anesthesia located in the palm of the hand: this slight

⁸ A. Pitres, *Leçons cliniques sur l'hystérie*, 1891, I, p. 74, and Gilles de la Tourette, *Traité clinique et thérapeutique de l'hystérie*, 1891, p. 161.

anesthesia near the fingers was, in fact, complete at the level of the thenar eminence. It involved damage from a more or less complete section of the median nerve, especially its superficial branches. But upon observing the patient, something singular was discovered: it was a hysterical woman who also had complete anesthesia on the left side, from top to bottom, without any complaint or mention of it. The doctor jokingly said to her: "How, young lady, you come to complain about an anesthesia that occupies only a very small region of the palm of the right hand, while, as you will notice, you are absolutely insensible on the entire left side." The young woman, startled and embarrassed, at first did not dare to respond, then with more confidence and a touch of irony, said: "What do you expect? I do complain when the anesthesia in the palm of my right hand bothers me, and I don't say anything when the anesthesia on the left side doesn't bother me." As for you, gentlemen, explain that as best you can.

The same remark can be made, I believe, for all the senses—even for the visual sense. There is a well-known illness among oculists, retinitis pigmentosa, which consists of a progressive sclerosis of the retina, advancing from the periphery toward the center. Naturally, such a lesion produces a progressive and concentric narrowing of the visual field. But these patients are extremely unfortunate; they can barely make their way down the street and make constant efforts to move their eyes in all directions—their visual field is so constricted. These excessive efforts cause discomfort and disturbances in the movement of the eyelids and the eye. Do hysterical patients suffer in the same way? Do they compensate for this narrowing with convulsions of the eyeball? Last Sunday, as I was coming into the ward, I saw several young patients playing ball in the courtyard. One must never miss the chance to make a psychological observation, and I noticed that among the most energetic and skillful at the game was a young girl whom I will introduce to you in a moment. She has in both eyes an extreme narrowing; her visual field to the right and to the left is no greater than 5° , that is to say, it is reduced to a single point. How is it that patients with retinitis pigmentosa can barely walk down the street when their visual field is reduced to 20° or 15° , while a young hysterical girl chases a ball and catches it in the air with a visual field narrowed to just 5° ? Have the oculist physicians sufficiently reflected on this little problem?

The preceding remarks on systematization, the intelligent distribution, and the mildness of hysterical anesthetics already show us that we are dealing with a very particular phenomenon that does not resemble other nervous lesions. A number of observations that we have had the opportunity to make in the past—and that many of you have likely also made from time to time—serve to strikingly confirm these remarks and increase our perplexity.

A few years ago, I was observing hysterical patients in a ward at the hospital in Le Havre, which had been graciously opened to me by my excellent friend Dr. Powilewicz. I was working more or less alone and without guidance, and I embarrassed myself at every moment with perhaps excessive zeal: you will see why. In order to be useful in the ward, I had taken on the task of electrifying the legs of a patient with hysterical paraplegia. She was completely anesthetic, as I had verified that day, had a considerable narrowing of the visual field, complete

achromatopsia in both eyes—in short, all the classic symptoms. In my naïveté, I was interested in the muscular contractions provoked by the contact of the negative electrode, and I passed my pad over her thighs and legs; when suddenly, an accidental incident shattered all my enthusiasm. The two wires connecting the pads to the device had probably come loose some time earlier, and I had in fact been electrifying her with two simple pieces of wood. My first instinct was to cry out and reattach the wires to the electrodes; but I remembered just in time the advice that M. Charcot had often given me: “With hysterical patients, never let yourself be surprised by anything: *nil admirari* should be your motto.” So then, let us not be surprised, and since, after all, muscular contractions had indeed occurred a moment ago, let us continue. I merely took the precaution of turning the patient’s head away and hiding the wires behind a screen: the contractions occurred even more clearly at the simple contact of the pad. This is not, you will say, such a marvelous thing; there is a kind of habit, a suggestion being carried out. That is my view as well, but I would simply like to know how this patient, whose entire skin was absolutely insensitive, could sense the moment when my pad touched her legs—in order to produce a movement at that moment, and only at that moment.

Around the same time, I made another equally embarrassing observation—it concerned the tactile sensations rather than muscular ones. I was studying, not at the hospital, but at home, a young woman of twenty-two whom I have often described to you by the name of Lucie. She had, more or less every day in the evening, a large hysterical attack that lasted more than five hours. Allow me to describe this interesting attack from several points of view. After a long aura, the patient would suddenly collapse backward, motionless, entirely contracted; she seemed to breathe with difficulty and her face became violet. This was followed by grand movements—archings, circular motions, salutes, kicks, etc.—and suddenly the patient would sit up with her eyes wide open. She stared fixedly at the curtains of her window and held her arms in the air in a position of terror. I later learned that at that moment she was experiencing a terrifying hallucination and believed she saw men hidden behind the curtains. This attitude, with almost no variation, continued without exaggeration for an entire hour. Then the patient moved more and more and entered into a kind of curious somnambulistic delirium, during which she had the peculiar habit of going down to the kitchen and pretending to be asleep while refusing to eat, though she had refused to eat the night before due to loss of appetite. This episode is remarkable, as you see, by its peculiar and somewhat classic character; let us not forget that this poor twenty-two-year-old woman lived in the outskirts of a provincial town, had never been in a hospital, and had never been seen by any physician. For now, let us focus on just one detail: I had noticed that as soon as I raised her arms and placed them in the position of terror, Lucie would immediately have a seizure. Nothing could be simpler or more well-known, you will say—you awaken the main idea of the seizure by evoking the position of the arms, and the rest follows. That is true, but there is one small detail: Lucie was anesthetic over her entire body and showed no trace whatsoever of muscular sense. Like the patient I presented to you recently, she collapsed abruptly as soon as her eyes were closed. Now, I often took the

precaution of closing her eyes before raising her arms, and yet the seizure began only when her limbs were placed in the intended position. How, then, was the idea of this position perceived by a subject so insensible?

The previous procedure, which consists of provoking the hysterical attack by means of sensations that appear to be perceived by the subject's mind, allowed me to reproduce a similar experience—not this time on muscular sense, but on visual sense. A few days ago, there was in the ward a sixteen-year-old boy having his first hysterical attack after the great fright he had experienced during a fire. As you can guess, he reproduced this episode in each of his attacks, cried “Fire!”, called for the firefighters, and thrashed about in the flames. It was enough, when he was calm, to speak to him of fire or especially to show him a small flame to provoke the return of the attack. One day, I placed him in front of the perimeter device to measure his visual field, had him close his right eye, and fix his other eye on the central point. He expected to see appear on the black arc a piece of white paper as he had seen before. But I carefully held behind him a lit match and moved it slowly toward the edge of the arc. The match had scarcely reached the 80-degree mark when the patient cried “Fire!” and collapsed in convulsions. There is nothing astonishing about this, since you know that the sight of a flame triggers the attack. But here again, an obscure question arises, as the patient had a narrowed visual field, and as I had measured it several times, his visual field was restricted to 30°, or at most 35°; my match, when it reached 80°, was obviously located in the part of the visual field that was invisible—in other words, its image was projected onto the anesthetic part of the retina.

This study of ocular anesthesia in hystericals can also be conducted in another way, which has already led several observers to make remarks similar to those we have just presented. Hysterical patients often present, upon examination, with complete amaurosis of one eye. But this loss of one eye seems to trouble them so little—like their other insensibilities, moreover—that one has been led to examine this symptom with a certain degree of rigor. Military physicians in regiments, very skilled in the art of exposing medical deceptions, have applied to hysterical patients with amaurosis the same methods they used during military medical evaluations. One of these methods consists of having the subject look into the Flees box; it is a small and very ingenious instrument that you see here: thanks to a system of mirrors, the subject who looks into the box with both eyes open sees on their right an object—a red wafer seal, for example—that is actually visible only to the left eye, and on their left a white wafer seal that is seen only by the right eye. Suppose an unsuspecting malingerer claims to be blind in the left eye. He will say that he does not see the point appearing on the left—he will omit the white point and mention only the red one appearing on the right. But that red point, in fact, can only be seen by the left eye. Now, let us show this box to a hysterical patient with amaurosis of the left eye: she will fall into the same error as the simulators, as did a young girl I am about to show you—or else, more naively still, she will see both wafer seals, as did a patient of M. Pitres.⁹

M. Charcot and M. Regnard observed a similar fact long ago in relation to hysterical dyschromatopsia. A patient could distinguish only red and did not see

⁹ A. Pitres, *Leçons cliniques sur l'hystérie*, 1891, I, p. 102.

the other colors, but if a Newton's disc painted with the seven colors of the prism was spun before her eyes, the subject saw a grayish-white hue form, as if all the colors had produced their usual effect on her.¹⁰ Later, M. Parinaud, the eminent head of the ophthalmology laboratory, took up the study of unilateral amaurosis again with great precision.¹¹ M. Bernheim also resumed and confirmed these experiments by comparing hysterical amaurosis with suggestive amaurosis.¹² M. Pitres likewise pursued research in the same direction, and the results he reached were in agreement with the conclusions of the preceding authors. I will not speak of the interpretation proposed by these authors—it seems to me, if not inaccurate, at least incomplete—but I retain the fact that their work brought to light: the hysterical patient appears blind only if questioned in a certain way; a large number of studies prove that the seemingly blind eye actually sees perfectly well.

In 1888, I myself arrived at the same result by less precise methods. A young girl at the hospital in Le Havre seemed to be absolutely blind in her left eye; she claimed to be in total darkness whenever her right eye was closed. One day, I was standing on her right and showing her images on which she was commenting; I slowly moved to her left while continuing to speak, and I was able to move the images clearly to her left side without her ceasing to see them. I even demonstrated—what is far more curious—that the subject retains the memory of an object shown only to the left eye while the right eye was closed.¹³ But we shall have occasion to speak to you more about this later. Let us conclude for now only this: that amaurotic patients continue to see with their blind eye; this is bizarre, but certain. But let us not imagine that this characteristic exists only in ocular anesthetics or that it must be explained by the difference between monocular and binocular vision. This contradictory feature—we have already encountered it in all hysterical anesthetics—is a general problem, not one specific to the visual sense.

Before entering into the discussion of this problem, I would like, gentlemen, to make it clearly perceptible to you, and for that, I am going to present to you some of the troubling phenomena I have pointed out. You will then have more courage to seek the solution with me. Here, gentlemen, is a twenty-year-old girl, Isabelle, who presents the type of the most ordinary hysteria: alcoholic father, neuropathic incidents in childhood, choreic movements, delayed and difficult puberty, chloro-anemia at sixteen years old, and as a result of grief and emotional shocks, persistent sadness, minor hysterical episodes, anorexia, and scattered small contractures. She is anesthetic on the left side—incompletely in the leg, completely in the arm, chest, and face. She has a very pronounced reduction of taste and smell, and amaurosis of the left eye. I carefully and rigorously verify all these symptoms before you; you see that the needle pierces the skin of her left

¹⁰ Gilles de la Tourette, *Traité clinique et thérapeutique de l'hystérie*, 1891, p. 346.

¹¹ Agrégation thesis of M. Grenier: *Des localisations dans les maladies nerveuses*, 1886; M. Parinaud: *Anesthésie de la rétine*, etc., *Bulletins de l'Académie royale de médecine de Belgique*, 1886; and by the same author: *Sur une forme rare d'amblyopie hystéro-traumatique*, *Bulletin médical*, 1889, p. 777.

¹² *Revue de l'hypnotisme*, 1887, p. 68.

¹³ *Automotisme psychologique*, p. 295.

arm without her seeming to notice it.¹⁴ Well then, we are going to propose to her a simple convention to quickly verify her anesthesia. We ask her to respond “yes” every time she is pinched on a sensitive area, and “no” when she is pinched on an insensitive one. Since she is very naïve, she accepts without hesitation. And you see this curious spectacle: although her eyes are carefully hidden behind a screen, she never makes a mistake and always says “yes” when I pinch her right hand, and “no” when I pinch her left hand. She is blind in the left eye and complains of being in total darkness when I close the right eye. I have her look into the Flees box, and she gravely tells us that she saw a red wafer seal. You know that it can only be seen with the left eye.

Now here is another young girl, Berthe, eighteen years old, whose history is nearly identical to that of her friend Isabelle: hereditary antecedents, nocturnal somnambulism in childhood, temporary contractures of the limbs, attacks of various kinds—sometimes followed by complete but fortunately temporary blindness in both eyes. She is left-side hemianesthetic, but I will experiment only on the arm, as it is the only place where the anesthesia is absolutely complete and indisputable, as you can see. She has completely lost her sense of taste and smell, and she presents above all an interesting narrowing of the visual field. It is the same for both eyes and is certainly less than 10°, as M. Parinaud, who recently examined her, told us. You can see that she sees a piece of paper only if it is very close to the central point of the perimeter—at a distance of 5° at most.

Let us first try to reproduce with her the observation that struck me so deeply in 1887, and which one could call *imaginary electrification*. I give her a pad to hold in her right hand, and with the other pad I lightly touch the skin of her left forearm, without her being able to see at what moment I touch it. Observe the strong muscular contractions, and how the hand jerks upward at the slightest contact. It is unnecessary to point out to you, gentlemen, that the battery is not working—as you can see, the zinc has not been lowered.¹⁵

I cannot repeat before you the experiment that consisted in provoking the seizure in that young man by showing him a match in the invisible part of the visual field—the patient is no longer in the ward. But I can reproduce on this young girl an experiment that, in my opinion, is just as demonstrative. I have accustomed her to falling asleep whenever she sees my raised finger in front of her—it is one of those cue-based suggestions that you are well familiar with. Well then! I place her at the perimeter device, with the right eye closed and the left eye fixed on the central point. I slowly move my finger along the arc of the circle—it has not even reached the 80-degree mark when Berthe has already fallen backward, hypnotized.

What do you think of these observations? What is your opinion on the state of sensitivity in these two young girls? If you had to write a report about them, what would you say? Are they sensitive on the left side? One can pierce their skin with

¹⁴ We are studying the ordinary anesthesia of hystericals, such as it is commonly observed and accepted in clinical cases.

¹⁵ One can guess that this fact is not here as natural as in my chance observation of 1887: it is obtained here by a suggestion, of which only the execution is of interest.

pins without them noticing. Are they insensitive? They respond as soon as they are touched, even lightly. Is Isabelle blind or not? Does Berthe have a narrowed visual field? These are clinical questions I put to you, and you see that their importance is very real if we want to understand hysteria. You will therefore not hesitate to follow me in some very simple psychological studies that may perhaps help us out of this confusion.

II

The human mind does not accept absolute contradiction in the phenomena it studies; it needs to understand—that is, to restore the unity that appears to be compromised. But to bring unity into the midst of diverse facts, one needs an idea, a theory: hypotheses may have flaws and dangers, but they are unavoidable. To renounce hypotheses is to renounce understanding, and even to renounce thinking. It is through them that science resembles art and poetry—they form that part of itself which the human mind must project into the facts in order to make them intelligible to other human beings. We therefore need a hypothesis to understand hysterical anesthesia.

This need is so real that, for a long time, superficial observers have explained in their own way—and by a convenient method—the contradictions presented by these patients. They claim not to feel, and by certain artifices, one proves that they feel perfectly. Therefore, their insensitivity is feigned, and your methods are nothing more than ways to deceive a deceiver and to expose trickery. One must admit that hystericals have not had much luck: in the past, they were burned as witches and accused of consorting with the devil; then they were attributed with every imaginable debauchery, and to the common people, they are still the embodiment of erotic passion. We believe ourselves more advanced, and so we invent hysterical simulation.

Perhaps one day you will be convinced that this so-called simulation exists only in the minds of physicians incapable of understanding a moral fact. Let me simply show you for a moment how crude and insufficient this explanation is. Do they have any interest in faking anesthesia for the sheer pleasure of having their arm pierced with needles? Do these young girls deceive the military review boards just to simulate unilateral amaurosis? Is this elaborate deception really consistent with the naïve simplicity of these two young girls I just showed you? How is it that, in all civilized countries, hystericals have always simulated the same thing from the Middle Ages to today? If hystericals were faking, would they be caught by traps as crude as those laid for them? And finally—do they boast about their anesthetics? But it is said that these patients are unaware of them. It is we who reveal their symptoms to them, and they might well say to us: “If you are not satisfied with our insensitivity, don’t talk about it—because we are not the ones who pointed it out, and we don’t insist on being considered insensible.”

We must move beyond these crude explanations, and since insensibility, like sensibility, is a psychological fact, we must ask psychology for a few notions about sensations. This phenomenon of sensation has been defined in a rather vague way: most psychologists admit, more or less explicitly, definitions similar

to that of Wundt: "Sensations are primitive states of consciousness that cannot be decomposed into simpler phenomena."¹⁶ In a word, sensations in psychology would be what atoms are in chemistry, and this notion seems fairly satisfactory in a general way. But most psychologists add a second formula to complete and clarify the first: "Sensation," they say, "is the phenomenon that occurs in me when I can say: I feel, I see."¹⁷ This second definition, far from clarifying the first, seems to us to be in complete contradiction with it.

The words "I see," "I feel," far from being applicable to a simple phenomenon, actually refer to a very complex phenomenon. One of the two words that these expressions contain—*feel*, *see*—can, at a stretch, be applied to a simple phenomenon, to a psychological atom. A physiologist, Herzen¹⁸, said that one could compare the brain to a vast room filled with an innumerable quantity of small electric light bulbs. From time to time, certain little lamps light up here and there; that is what the words *I feel*, *I see* would refer to, if they designated only an isolated sensation, "red." But it is far from being the case for the words *I*, *me*; these are enormously complex terms. It is the idea of personality; it is the gathering of present sensations, the memory of all past impressions, the imagination of future phenomena, it is the notion of my body, my capabilities, my name, my social situation, my role—it is a whole network of moral, political, religious thoughts, etc. It is an inner world, the most considerable there is, and one we could never know entirely, because we ourselves have never seen it all. There are thus in the words *I feel* two things at once: a new psychological fact, a tiny spark that lights up in the brain, and that immense mass of pre-existing thoughts organized into the *I*. These two things intermingle, combine, and it is only by doing so that the already-formed personality seizes and absorbs that new sensation that has just occurred. If I dared—and it is not all that absurd—I would say that the *I* is like a living animal extremely large, whose antennae stretch across the entire visual field as an extension to grasp every new luminous point. And so, the small sensation that is born next to it is instantly caught and absorbed.

This operation of assimilation and synthesis is repeated for every sensation that arises in us—and a great number of them arise at every moment, originating in all those thousands of impressions that our senses are incessantly receiving. We can then conceive of what is commonly called *sensibility* as a two-stage operation.

First stage: it takes place in the mind, in the cortical cells of the brain, if you will—a very large number of small elementary psychological phenomena arise as a result of countless external stimuli. These are phenomena due to the tactile sense T T' T'', the muscular sense M M' M'', the visual sense V V' V'', and the auditory sense A A' A''—to mention only these as examples. Call these phenomena what you will: *elementary sensations*, *affective states* (to use the expression of a well-known French psychologist, Maine de Biran, whom medical students will one day have to study), or simply *subconscious phenomena*; just remember that they are

¹⁶ Wundt. *Psychologie physiologique*. Traduct. 1886, I, p. 305.

¹⁷ On these psychological discussions, consult *Automatisme psychologique*, pp. 39 and 305.

¹⁸ Herzen. – *Le cerveau et l'activité cérébrale*, 1887. Consult the entire excellent chapter on consciousness and personality, p. 197.

simple psychological facts that occur without the involvement of the idea of personality.

Second stage: a gathering takes place, a synthesis of all these elementary phenomena, which are combined with one another and, above all, combined with the vast and preexisting notion of personality.

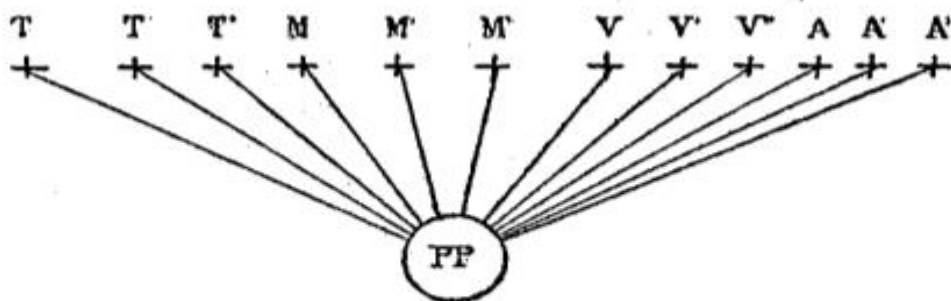


Fig. 1.

It is only after this operation that we become aware of feeling this or that impression, that we can say: "*I feel*." I propose to designate this new operation by the name *personal perception* (PP): it is indeed a perception—that is, a more complete and clearer form of consciousness; the word *personal* will prevent you from confusing this operation with external perception, which we are not discussing here, and it will remind you that its essential characteristic is the addition of the notion of personality.

The description and the diagram we have just studied are obviously theoretical and can apply only to an ideal man, not to a real man. In fact, no man is capable of bringing together, at every moment, within a single personal perception, all the elementary sensations that arise in him from all sides. In even the most well-constituted person, there must be a multitude of elementary sensations produced by the first operation that escape the second. These phenomena—such as T or M in figure 2—remain what they are: subconscious sensations, real no doubt, and capable of playing a considerable role in the psychological life of the individual, but they are not transformed into personal perceptions and do not become part of the personality. The person—the "I"—will therefore say: "*I feel*" about phenomena V or A that he grasps and perceives, but will not register the existence of T or M and will say of them: "*I felt nothing*." What is the normal number of elementary sensation phenomena that a person can thus bring together into a personal perception? I do not know, but I believe it varies greatly depending on a thousand circumstances, and I propose that we call this the *extent of the field of consciousness*—that is, the maximum number of such phenomena that an individual can, at a given moment, bring into personal perception.

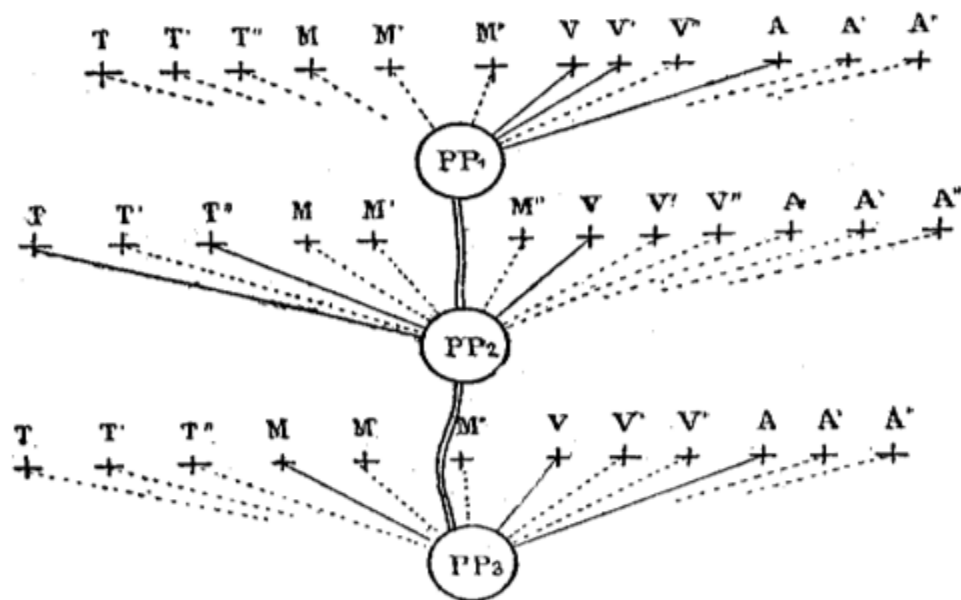


Fig. 2.

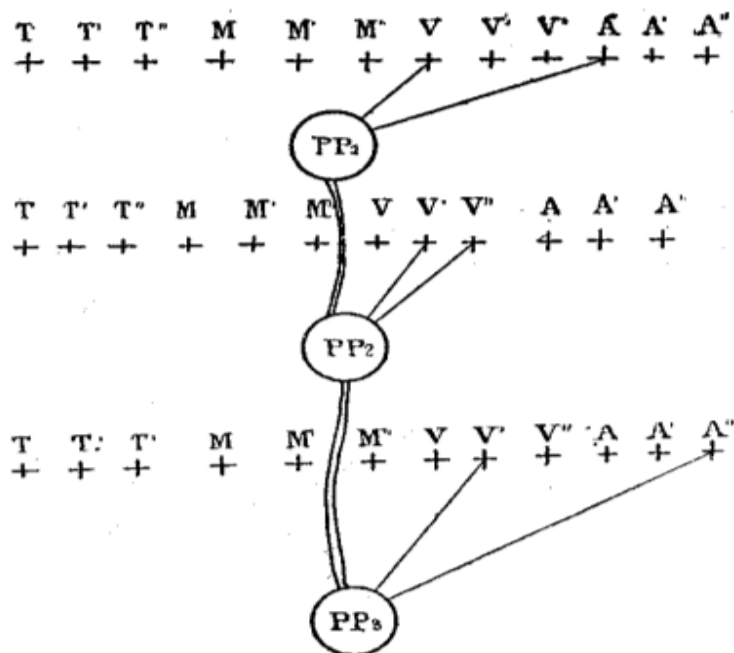


Fig. 3.

Suppose that this field of consciousness is very narrow in a given individual—then he will not be able, for example, to perceive more than three elementary sensations such as V V' A' at any given moment, and will leave the rest in the subconscious. It might seem that a considerable emptiness is produced in his mind. Not necessarily, for in the next moment, he can easily, by directing his attention differently, return to the perception of those tactile sensations that were previously left aside, and in a third moment, he can form a personal perception even with muscular sensations M. For example, in the first moment, he will look at and listen to someone speaking, without paying attention to the tactile impressions that continue to reach him; in the second moment, he will look at an object while touching it and will appreciate the contact—this time being aware of the surrounding sounds. In the third moment, he will write to dictation, perceiving the sound of the voice, the sight of the letters, and the muscular movements. You see that, in this case, there are no real anesthetics; if one examines each sense in turn while drawing the subject's attention to it, one will see that he can perceive all the impressions. Such an individual who already has a very reduced field of consciousness is not anesthetic—he is simply *distracted*.

But let us go further, and suppose that the field of consciousness narrows even more: the patient can no longer perceive more than two elementary sensations at once. Out of necessity, he reserves this personal perception for the sensations that seem to him—rightly or wrongly—the most important: the sensations of sight and hearing. He must become aware of what he sees and hears, and he neglects to perceive the tactile and muscular sensations that he believes he can do without. At first, he might still be able to turn his attention back to them, to bring them once more into the field of personal perception—at least for a moment. But the occasion does not arise, and little by little, the bad psychological habit sets in. A thousand circumstances, examples, suggestions, even well-meaning medical investigations, may have a large influence in shaping and fixing such habits. Nothing is more serious or more resistant than these moral habits, and there are many illnesses that are nothing more than psychological tics. One fine day, the patient—because you can guess that he has now become a patient—is examined by a physician. He is pinched on the left arm, asked whether he feels the pinch, and to his great surprise, the patient realizes that he no longer knows how to consciously feel it, that he can no longer, so to speak, recover in his personal perception sensations that have been neglected for too long: he has become anesthetic.¹⁹

These are, gentlemen, hypotheses—but they have been devised to explain as simply as possible the facts we have observed. They consist in supposing a small number of important things, of which the two main ones, I believe, are as follows:

(1) Sensations exist in the human mind in two different forms: as personal perceptions, characterized by full consciousness and the notion of personality, and as elementary sensations—subconscious ones—not connected to the personality;

¹⁹ A more detailed discussion of these psychological theories can be found in *L'Automatisme psychologique*, 1889, p. 305.

(2) Personal perception can disappear, while elementary sensations persist; this disappearance of personal perception occurs through a mechanism similar—though not identical—to what is known as distraction.

III

A hypothesis must always be verifiable by its consequences, and it is easy to foresee that the preceding propositions—if they contain any truth—must bring with them numerous consequences that are accessible to observation. The main supposition we have made is that of the permanent existence of elementary phenomena, of subconscious sensations, despite distractions and hysterical anesthetics. If such sensations exist, you will say, they must be able to manifest, because even elementary sensations always play a certain role. This is indisputable, and we must now look for these manifestations in the subjects I have presented to you.

You know, without my insisting on the theory behind this phenomenon, that sensations are followed by movements; well then, the sensations we are speaking of—even those not felt by the subject—manifest through movements that are often very visible. First of all, you are aware that most reflexes are preserved in hysterical anesthesia. M. Charcot recently showed us a man who was absolutely anesthetic on the left side. It was enough to lightly brush—even without his awareness—the anesthetic skin of the abdominal wall on the left side to provoke the contraction of the underlying muscles. This is Rosenbach's abdominal reflex, whose preservation was evident. The cremasteric reflex also appeared when the inner side of the anesthetic left thigh was touched.²⁰ The vasomotor circulatory reflexes are also perfectly intact, as my friend M. Hallion demonstrated last year by means of a very ingenious device. The pupillary reflexes to light and accommodation are intact, as you can observe—even in Isabelle's amaurotic eye—and yet these reflexes depend on retinal sensitivity. You also know that, in the normal state, the pupil dilates when any sensitive organ is stimulated, and in these two young girls you can observe this curious phenomenon, first reported, if I am not mistaken, by M. Pitres. The pupil dilates when one pinches hard—even their anesthetic left arm.²¹

These are reflexes that you consider to be entirely organic, although they are nonetheless connected to sensibility. I am going to show you phenomena of the same kind, which may seem even more curious to you. Into the anesthetic hand of Berthe, I place an object without warning her and without her being able to see it. You see what happens: she grasps and feels the pair of scissors that I placed in her hand, she slips her fingers into the rings, and her hand begins to open and close the scissors alternately. Under the same conditions, I place a smaller object in her hand; you observe that the hand makes back-and-forth movements as if to sew fabric—she is holding a needle. In short, these sensations, seemingly unfelt, regularly provoke the movement that would follow them under normal conditions.

²⁰ Cf. Pitres, *op. cit.*, I, p. 71.

²¹ Cf. Pitres, *op. cit.*, I, p. 73.

Sensations are also—and very often, in fact—the starting point of what is called, in psychology, the association of ideas. A sensation becomes a kind of signal, from which arise in the mind memories or varied images. This is what happens when we see a flag, when we hear the bell that makes us think of the arrival of the chief physician, or simply when we look at letters written on a piece of paper. Well then, I established in the mind of this young girl an association of this kind: I tell her that at the moment I touch her thumb, she will see a butterfly before her, and that at the moment I touch her little finger, she will see a bluebird. This is obviously a suggestion—but observe for a moment how it is carried out. I turn her head away and block her view with a screen, and then I lightly touch the little finger of the left hand, the anesthetic hand—let’s not forget—and Berthe exclaims: “Oh! The beautiful bluebird!” Without warning her, I now touch her thumb, and she exclaims: “It’s no longer a bird, it’s a butterfly.” She never makes a mistake; so the sensation of contact on the little finger must in some way exist in order to so consistently produce the image linked to it. Would you like to repeat this experiment in a different form? Here is Isabelle, who is blind in her left eye. I give her a suggestion of the same kind: “When I show you a blue color, you will hear bells ringing.” We close her right eye and show colored wools to her left eye, the amaurotic one. At the first wools, she says nothing, thinking she is in total darkness. Suddenly she exclaims: “Ah! I hear bells!” Look: it was exactly when I showed the blue wool to the blind eye. This experiment could be repeated in a hundred ways on these patients or others—it would always produce the same result.

Finally, gentlemen, sensations have yet another consequence, which may be even more important—they leave behind memories. I have previously demonstrated that impressions made on anesthetic organs leave behind memories that can, more or less easily, be made to reappear.²² These earlier experiments were not always easy to reproduce quickly, but here is one that has just now succeeded. I hide Berthe’s head behind a screen, and I place a small object in her left hand; she touches it, feels it, but cannot tell what it is, and declares she feels nothing. I pass a bottle of scent under her nose—she inhales and smells nothing, as you know she is completely anosmic. This done, I put her into somnambulism. It is within this particular state of somnambulism that the phenomenon occurs, which no longer surprises us, as my friend M. Guinon just reminded us here recently, there is a wide variety of different somnambulistic states. You will allow me today to make use of this somnambulism without explaining its nature. Now that she is asleep, I ask her what she had in her left hand earlier, and what she smelled under her nose. She responds without hesitation: “You placed a small bouquet of flowers in my left hand, and you made me smell a bottle of orange blossom water.” The memory is perfect—so I have the right to suppose that the sensation had indeed occurred.

I realize, gentlemen, that I have shown you examples of subconscious sensations borrowed from various senses, and that I have left out an extremely important one: the muscular sense. Perhaps this is because the two young girls I presented to you do not have muscular anesthesia deep enough for the

²² Automotisme psychologique, p. 295.

experiments to be of interest. We will now bring in another patient who presents a clearly indisputable muscular anesthesia. Here is Marguerite, a twenty-three-year-old young woman whose somewhat complicated history I will not recount. I present her to you only for a single symptom: she is absolutely anesthetic on her right side, and when I move her right arm without her seeing it, she is not even aware of its existence. When she does not see it, she cannot even move her right arm; this is, in my view, a kind of hysterical paralysis, which is not apparent in the normal state thanks to a psychological compensation—the replacement of movements through visual imagery. I will not dwell on these facts here, interesting though they are; I will simply point out that they demonstrate the absolute muscular anesthesia of her right arm.

Well then! I intend to show you that muscular sensations do indeed occur and that they leave behind memories capable of reappearing. To show you this with precision, we will make use of a small device that is both simple and ingenious. M. Jean Charcot, who was an intern last year in his father's department, built this little instrument to study certain cases of agraphia. It is, as you see, a long wooden stick mounted on a gimbal and movable in every direction. The subject holds the stick by the middle as he would a penholder, and after turning her head away, I take this same stick by its lower end and guide the tip to write a word on the paper. The subject's hand—if it were sensitive—would have felt all the movements necessary to write this word; the apparatus allowed us to make her experience these very delicate sensations with precision and to preserve them as a result in the written trace of the word I wrote. Marguerite tells us that she felt nothing at all. We know this means only that she had no personal perception of anything; but did she really have no elementary sensation? To verify this, I place a pencil in the subject's completely anesthetic right hand and turn her head away. You can see her fingers first surround the pencil and position themselves in the way needed to write. It is the same phenomenon we previously observed when Berthe held the scissors. But now, here is the right hand beginning to write. How can such a delicate movement occur, when a moment ago the subject couldn't even move without watching? Allow me, gentlemen, not to explain this phenomenon today—it is too complex; let us simply observe the results. The hand wrote the word *Jean*, the name of the device's inventor. Observe, gentlemen, that I myself had written that same word with the same letter forms. Is this not solid proof of the persistence of memory? And doesn't this very memory show us that muscular sensations did in fact occur in some manner, even if the subject had no personal perception of them?

Our hypothesis also claimed that the loss of this personal perception was a phenomenon analogous to distraction; but then, you will say, attention ought to be able to modify hysterical anesthetics. Quite right, gentlemen, I agree with you, and this is another consequence to verify; just do not forget that attention is very difficult to fix in a hysterical patient and that this experiment may not always succeed. On Berthe's left hand, which is anesthetic, I press a red sealing wafer: she looks surprised and stares at it intently. Let us leave her for a moment, then, while her head is turned, we lightly pinch the same hand that a moment ago was insensitive. Here is Berthe exclaiming that I am pinching her and that she feels it

perfectly. It is true that this brief return of sensitivity will not last long—I remove the sealing wafer and a moment later she no longer feels anything.

If attention momentarily causes already existing anesthetics to disappear, then distraction must temporarily produce new insensibilities, analogous to hysterical anesthetics. This too is accurate. I take Berthe aside and speak to her about a topic that excites her greatly at the moment—the mid-Lent ball and the beautiful costume she will wear. During this time, as you can see, I pinch and prick her right arm, which just moments ago was sensitive, and she doesn't notice it at all. Her field of consciousness is so narrow that it has momentarily lost the tactile sensations from the right side that it usually includes—when it is not filled with other images. Is it not the case that the main consequences we could draw from our hypotheses are now being confirmed before your eyes?

Before concluding, gentlemen, just one general remark. Can all the experiments I have just shown you be easily repeated on any hysterical patient? To what degree of generality should we accord the preceding hypotheses concerning hysterical anesthesia? I will answer you quite frankly: I have observed and grouped three main categories of different patients:

(1) The group that most interested me is made up of patients like the two young girls, on whom one can easily repeat all these experiments and many others besides. I have studied and described others, in 1887 and 1889, of the same type as those I had studied in Le Havre. I also found some quite similar patients among those I have followed in Paris; my brother Dr. Jules Janet has repeated these experiments on two patients whom he brought to my attention. M. A. Binet²³ has repeated them as well on several subjects with interesting variations. M. J. O. Onanoff²⁴ has independently studied similar phenomena with great experimental precision, since he was able to record on the smoked cylinder of a kymograph the subconscious movements of hysterics provoked by the touching of their anesthetic limbs. Finally, foreign observers—Messrs. Gurney and Myers in England, Mr. Max Dessoir in Berlin—have published quite analogous observations. I believe it would not be difficult today to gather about thirty cases of hysterical anesthesia behaving in exactly the same way. To me, these are the most typical cases of hysterical anesthesia, just as I understand it.

(2) In a second group, I would place the very numerous patients who, by certain characteristics, are analogous to the previous ones, but in whom all these

²³ M. A. Binet, in his work *Les altérations de la conscience chez les hystériques* (*Revue philosophique*, 1889, vol. I, p. 35), showed an interesting method for revealing the subconscious sensations of anesthetized limbs. The old and natural associations between these seemingly vanished sensations and the subject's other thoughts persist in some cases, despite the anesthesia; it is possible, for example, to provoke such-and-such a thought in the subject's mind solely by the movements made in the anesthetic limb.

²⁴ M. J. Onanoff, in his study *La perception inconsciente* (*Archives de Neurologie*, 1890, p. 364), sought to determine the reaction time—that is, the time that elapses between the moment of a stimulus perceived unconsciously and an unconscious act that may be considered a response—under experimental conditions to a given stimulus. He found that this time is much shorter than it would normally be when the stimulus is applied to a sensitive area. There would thus be a way to objectively identify a subconscious reaction distinct from a conscious one. We fear only that the reaction time of subconscious phenomena may vary greatly depending on various conditions, but we are happy to note this new evidence for the existence of subconscious sensations in hysterical anesthetics. These same studies are also summarized in the latest book by MM. P. Blocq and J. Onanoff: *Sémiologie et diagnostic des maladies nerveuses*, 1892, p. 199.

experiments cannot be repeated with the same result. For example, in them one can easily bring out the persistence of visual sensation in the amaurotic eye when both eyes are open, but one does not succeed as well in demonstrating it when the healthy eye is closed. For me, these are patients who are either unrefined or rather complex, and who can without too much difficulty be linked to the previous type.

(3) But there is a third category of patients whose existence I do not doubt and in whom we are never able to bring to light any trace of subconscious sensation. Well then, gentlemen, I leave it to you to adopt whatever hypothesis you wish concerning these patients. You may believe that they are absolutely different from the previous ones and that in their case anesthesia is not just a disturbance of personal perception, but a suppression of all sensation. But consider the consequences of your supposition: you will create a category of hysterics entirely different from the previous ones, you will imagine in them an anesthesia analogous to organic anesthesia, and then you will need to explain to me the intelligent distribution of that anesthesia, the complete indifference with which the patient tolerates it, the preservation of reflexes, etc. And I ask myself from what point you separate these patients from the others and how you then create two kinds of disease within hysteria. You may also suppose that these new patients are like the previous ones and that for some reason you are simply not able to bring out the existence of subconscious sensation. There are a thousand conditions—degree of suggestibility, selectivity, greater or lesser grouping of subconscious phenomena—that can vary the outcomes of experiments. You are free to choose, but I do not hide from you my preference for the latter hypothesis.

The psychological hypotheses that I have presented to you do indeed seem to me to have serious advantages. They explain the systematized anesthetics, the distribution of localized anesthetics, the indifference of the patients—since the illness disturbs only conscious perception and leaves intact all the automatic phenomena of everyday life. They explain the oddities that have long existed in the study of amauroses and anesthetics, and they allow us to eliminate that absurd supposition of hysterical simulation, to which one had constantly resorted in order to explain what one did not understand.

We can therefore conclude: hysterical anesthesia is not, for us, an organic illness—it is a mental illness, a psychological illness. It exists not in the limbs, nor in the spinal cord, but in the mind—represented, if you like, by the cortical regions of the brain. In the mind itself, it involves a very particular phenomenon; it is not at all an alteration of elementary sensations, which remain as they are and retain all their properties. It involves a very special operation: that of personal perception, which allows us at each moment of life to connect new sensations with existing ones and to link them to the notion of personality. It is due to a weakness of this synthesis of psychological elements that I once called psychological disaggregation. Hysterical anesthesia is a disease of the personality.